Yfoundations

Inquiry into Child Protection and Social Services 2020

About us

For over 40 years, Yfoundations has served as the NSW peak body representing children and young people at risk of and experiencing homelessness, as well as the services that provide direct support to them. We are backed by a strong board, with over 100 years' combined experience working in youth homelessness.

The Yfoundations' approach focuses on five foundations: safety and stability, home and place, health and wellness, connection and participation, and education and employment. We believe all five foundations must be present for young people to live flourishing and meaningful lives.

Introduction

Abuse and neglect in early life not only have enduring social, psychological and neurobiological effects for survivors, it is also one of the leading causes of youth homelessness across the globe (Embleton et al., 2016). In turn, youth homelessness can exacerbate childhood trauma, and increase exposure to danger, stress and risky behaviours (Martijn & Sharpe, 2006). This means that youth homelessness is both an outcome and a primary indicator of the maltreatment of children and young people.

Given this intersection, Yfoundations has a strong interest in improving the operation of the child protection system in NSW. As such, our organisation welcomes the Committee on Children and Young People's Inquiry into child protection and social services system. We appreciate this opportunity to advocate on behalf of our state's vital youth homelessness sector, with the aims of improving long terms outcomes for the extremely vulnerable children and young people they support.

Focus and overview

Large numbers of unaccompanied child and young people access Specialist Homelessness Services (SHS)[1] every year in NSW. As indicated in Table 1, which contained data that Yfoundations commissioned from Australian Institute of Health and Welfare, there has been a welcome decrease in the number of 12 to 17-year-olds accessing SHS in the 2019-20 period. However, at 5,699, this number remains unacceptably high.

Table 1: The number of unaccompanied 12 to 17-year-olds accessing SHS' in NSW, 2014-2019

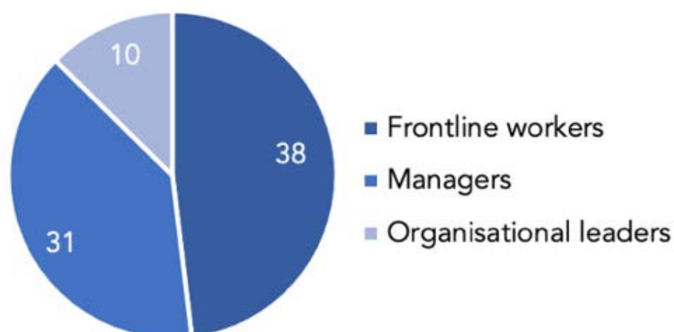
	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
12 - 15 years	1,420	2,042	2,415	2,485	2,588	2,381
16 - 17 years	2,870	3,486	3,728	3,570	3,889	3,288
Total	4,290	5,528	6,143	6,055	6,447	5,669

[1] For convenience, we will use the term 'SHS providers'; however, we acknowledge that the youth homelessness services consulted received funding from diverse funding sources at the time of this submission.

Across these age groups and time periods, the primary reason that children and young people sought SHS assistance was "relationship/ family breakdowns". Evidence suggests that many of these breakdowns occur in the context of intergenerational cycles of abuse and neglect. The recently released evaluation of the Homelessness Youth Assistance Program (HYAP) found that the majority of 12 to 15-year olds who received support had previously been subject to at least one Risk of Significant Harm (ROSH) report – primarily because of concerns about their caregiver's behaviour, in addition to the risks that child and young people presented to themselves (Taylor et al., 2020).

This submission will focus primarily on those within this highly vulnerable group who are on the "edge of care" (Thornton et al., 2020): they have fled or been 'kicked out' of their home, but have not been subject to Care and Protection Orders.[2] Speaking to the terms of reference regarding the child protection intake, assessment, referral and case management system, we will stress the urgent need for a more timely, proactive response to these at-risk adolescents – who are often considered "too hard" for the child protection system (Robinson, 2017). The latter part of this submission will focus on terms of references regarding the adequacy and availability of early intervention, prevention and family preservation programs to prevent this group from entering the child protection and homelessness system in the first place.

Chart 1: SHS participants in Yfoundations child protection survey



Commenting on this highly vulnerable cohort, Yfoundations draws on our extensive experience working at the intersection of the child protection and SHS system. We also conducted 19 interviews with leaders in the youth homelessness sector for this submission and surveyed an additional 82 workers (see Chart 1).

Our recommendations, which build on those of the recently released HYAP evaluation (Taylor et al., 2020) and the *More than Shelter* report (NSW Ombudsman, 2020), include:

- Reviewing the child protection assement and triage process, to ensure that children and young people being accommodated in SHS are still classified as 'homeless' and are assessed based on their vulnerability level rather than their age
- Improving the effectiveness of the nominated CSC contact person, and their relationship with SHS providers
- Increasing the number of adolescent-specific caseworkers across the state
- Expanding the range of OOHC placements types meet the diverse, complex needs of at-risk adolescents, including Treatment Foster Care, Therapeutic Residential Care and Secure Care placements
- Reviewing the role of voluntary OOHC in the NSW service system
- Supporting appropriate young people to live in and transition from medium-term SHS placements
- Increasing funding for evidence-based early intervention programs

[2] Yfoundations recognises that the problems of homelessness affect a much broader group of young people, including the 'hidden homeless', however, we have decided to focus on the pressing needs of a particularly vulnerable cohort identified by the SHS sector.

The issue

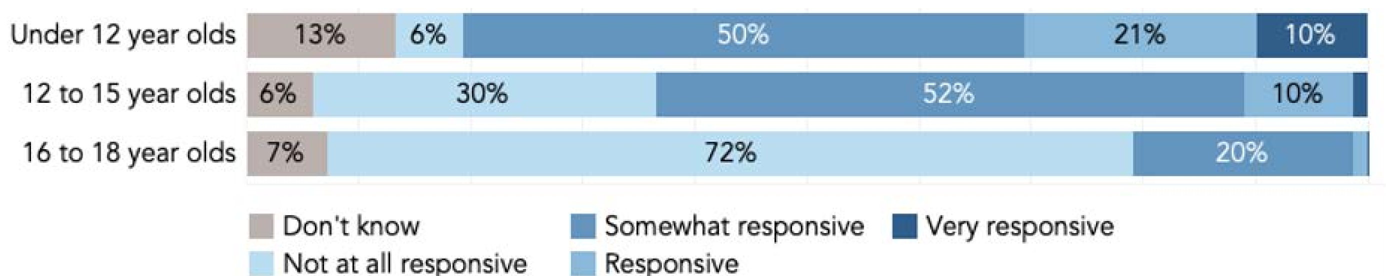
In our conversations with leaders in the youth homelessness sector, one key concern was repeated over and over: their struggles in getting a response from the child protection system regarding 12 to 17-year-olds. Generally, it was felt that DCJ workers prioritised the needs of younger children – particularly those aged five and under – and all but ignored reports regarding adolescents and teenagers. Many SHS providers expressed frustration at being required to make numerous mandatory child protection reports every week, despite knowing they will not receive any response.

> "We will complete a mandatory report every time we believe there is a Risk of Significant Harm for that young person. So we have a couple of young people where we've done 60 and 70 reports to DCJ, and DCJ have pretty much said to us 'stop doing them we're not going to do anything for this young person'".
>
> **SHS Manager**

> "I actually have zero expectation that there will be any sort of support or acknowledgement of anyone pretty well over 14 or 15. There's nothing there. You can report until the cows come home, and you know nothing is going to happen... I don't know how urgent you'd have to be to receive a response."
>
> **SHS Leader**

These views were reflected in the responses to Yfoundations' SHS survey. As indicated in Chart 2, 30% reported that DCJ was "not at all responsive" to child protect reports from SHS providers regarding 12 to 15-year-olds, and 52% reported that they were only "somewhat responsive". More concerningly, 72% of SHS providers reported that DCJ was "not at all responsive" to reports for 16 to 17-year-olds, and a further 20% reported they were only "somewhat responsive".

Chart 2: SHS survey respondents to question, "In your experience, how responsive are DCJ to child protection reports from SHS providers regarding young people aged..."



Several survey respondents raised concerns that both the Helpline and CSC triage process tend to screen out children and young people who are reported by SHS providers, based on the assumption that "our service reduces/ eliminates risk". Similarly, our interviewees complained about tendency of DCJ "dump and run": to refer a highly vulnerable young person to their service, and then close their case "the minute" their referral is accepted – on the grounds that the young person is no longer at risk because they have accommodation.

Many SHS providers reported that they felt that their services were providing a "quasi out of home care replacement model" for some child and young people who have no prospect of family reunification. However, unlike OOHC providers, SHS providers do not have parental responsibility and do not receive the same levels of casework support and access to funding and services. This made it particularly difficult for them to support young people with high needs and challenging behaviours, who may disrupt the dynamics of the youth refuge during their often-brief stays and then self-place in high-risk environments.

"We don't push DCJ unless we believe that the young person needs to enter care. And we're not advocates of that, trust me. We don't want people entering care. We would prefer them to have a family or community response. But sometimes there's no other options."

SHS Leader

Case study

Jane* was 12 years old when DCJ first referred her to a girl's refuge called Miriam's Place*. She had been reported to child protection after disclosing to a teacher that her father had sexually assaulted her. Jane's father has since been sent to prison, and her mother had no interest in supporting her because of her severe mental health issue: as a result of her early trauma, she had become a chronic self-harmer who experienced constant suicidal ideation.

As such, Jane had continued living with her stepmother in the same apartment where the sexual abuse had occurred. At the time of the referral, she was in and out of psychiatric units and had made it clear to her doctors and caseworkers that she no longer wanted to stay living there. However, she was not eligible for Miriam's Place at that point – the service only accepted girls aged 13 to 17. Instead of placing her in OOHC care, the DCJ caseworker tried to reunify Jane with her biological mother. When the placement quickly broke down, she was sent back to stepmother's apartment.

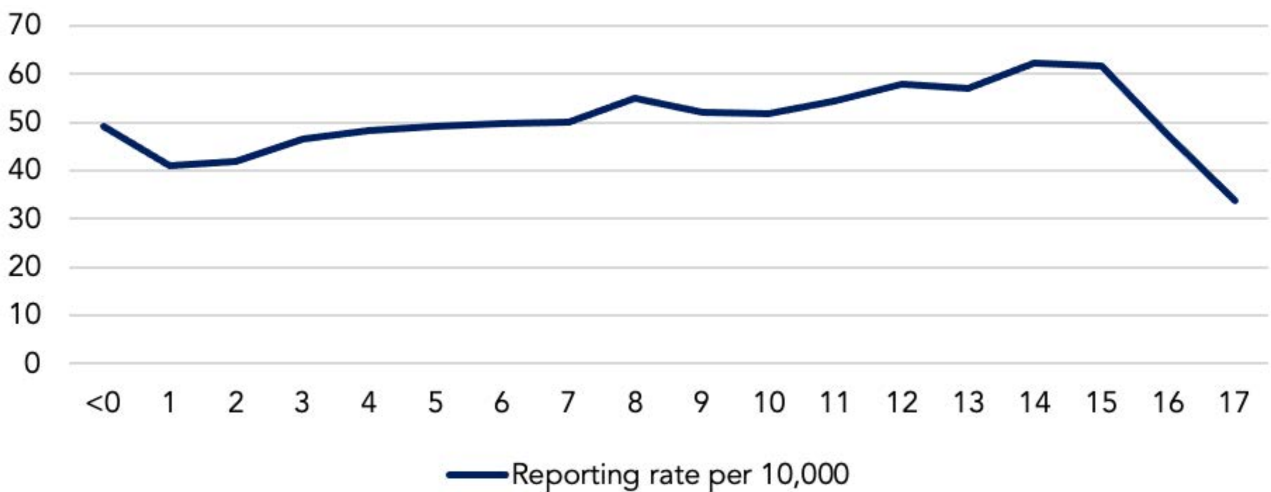
Jane moved into Miriam's Place as soon as she turned 13, and shortly afterwards DCJ closed her case. While she is now receiving trauma-informed care, she has no contact with any of her family and continues to suffer from severe mental health issues. The manager of Miriam's Place is frustrated that Jane was not removed from a traumatising situation earlier, and that child protection has not maintained their involvement in her case. In her words: "if this is not a young woman who needs to be in the minister's care, I don't know what the criteria is!"

*Name changed for privacy

The evidence

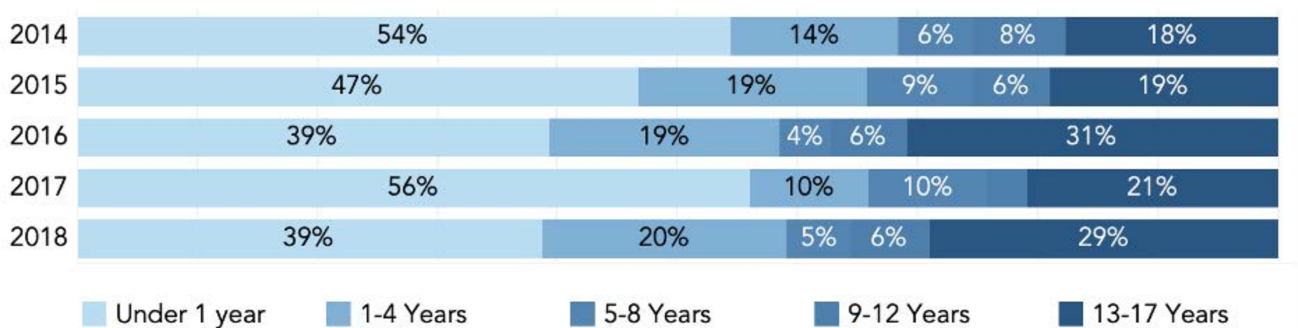
The idea that 12 to 17-year-olds are the least vulnerable young people flies in the face of DCJ's own data. As highlighted in Chart 3, ROSH reporting rates are, in fact, highest for 12 to 15-years-olds.[3] These concerning trends are consistent with national and international research, which suggests that experiences of maltreatment and victimisation can accumulate with age (Gorin & Jobe, 2013). Social and biological influences also mean that adolescence is a time of increased risk-taking, particularly among those who do not have strong parent-child relationships (Qu et al., 2015).

Chart 3: Rate of children and young people involved in ROSH reports per 1,000 population by age, 2018-2018



This risk-taking behaviour helps explain the alarming death rates among vulnerable teens. Each year, DCJ's Serious Case Review teams report on the death of children and young people' known to DCJ' – meaning they or their sibling were the subjects of a ROSH report in the previous three years. As highlighted in Chart 4, those aged 13 to 17 have consistently been the second-highest age group of reported deaths, behind babies less than a year old.

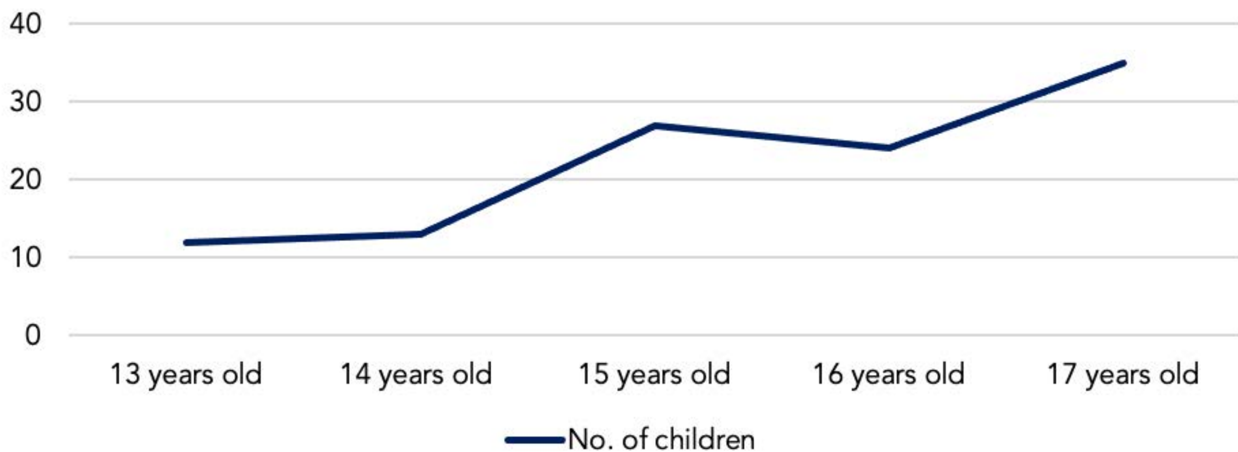
Chart 4: Age at death of children known to child protection in NSW, as reported in 2014 to 2018 Child Death Annual Reports



[3] Report rates fall sharply at 16, but this likely reflects the fact that school dropout rates among young people experiencing homelessness, drug addiction, mental illness and behavioural issues (Gubbels et al., 2019; MacKenzie et al., 2016), and teachers are the primary reporters in NSW.

In 2014, when the Serious Case Review team completed a cohort review on this age group, they found that 85% of the 130 teens who died between 2009 and 2013 did so in 'vulnerable' circumstances. Suicide was the leading cause of death among 13 to 17-year-olds (36%), followed by transport accidents involved risk factors such as young or intoxicated drivers, too many passengers and speeding (30%), illness involving medical neglect (17%) and drug overdose (7%). Counter to the assumption that those over 16 can "look after themselves", the Serious Case Review Team also found that death rates increased with age (see Chart 4).

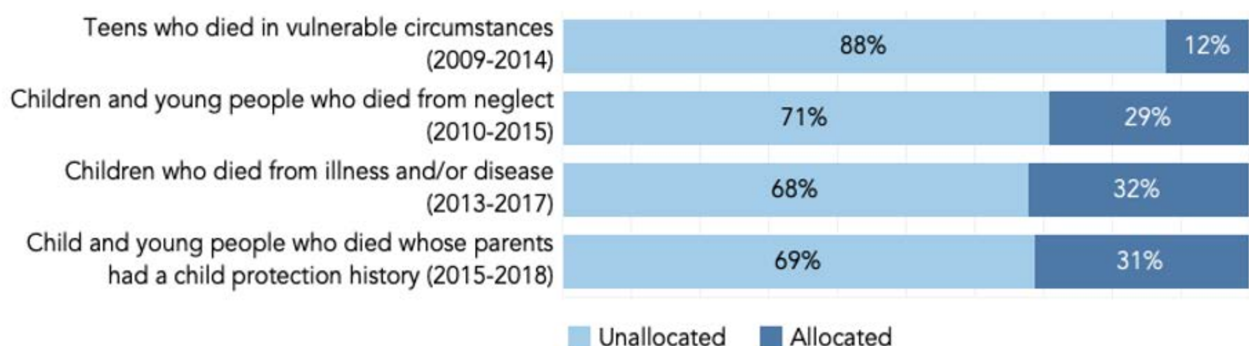
Chart 5: Age at death of teens known to DCJ, who died in vulnerable circumstances between 2009 and 2014, as reported in 2014 Child Death Annual Report



The Serious Case Review data shows that DCJ was aware of the warning signs among this group. Some 31% of the 111 teenagers were recorded as having a diagnosed mental illness, and 77% were involved in "risk taking behaviours" before their death – including alcohol and drug misuse, transport related risk taking, absconding from home or placements, criminal behaviours, high risk sexual behaviour, suicidal ideation, self-harming and problematic relationships with adults. A quarter of the cohort was not living with their families at the time of their deaths: 11% were homelessness, and 18% has experienced "periods of homelessness or housing instability that contributed to their vulnerability" (NSW Government, 2014).

Despite the evident risk to this highly vulnerable group of teenagers, only 12% had an allocated caseworker at the time of their death. Of these, only 7% had had recent contact with their caseworker. In contrast, the much younger cohorts that the Serious Case Review studied in subsequent years had significantly higher allocation rates – sitting around 30% (see Chart 6).

Chart 6: Allocation rates in the Child Death Annual Report cohort studies of children and young people who were known to DCJ

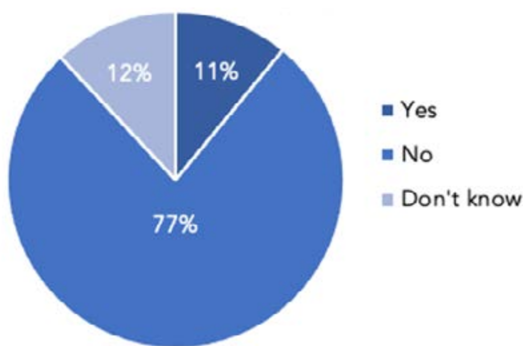


Our recommendations

ROSH and allocation thresholds

As indicated in Chart 7, more than three-quarters of Yfoundations survey respondents felt that the current ROSH threshold is not appropriate with regards to unaccompanied children and young people who access homelessness services. They were specifically concerned that the ROSH threshold didn't give sufficient weight to homelessness, or assumed homelessness was the only risk – meaning they downgraded young person the moment they had a roof over their head. They also suggested that current assessment processes made the false assumption that adolescents could 'self-protect' (Robinson, 2017).

Chart 7: SHS survey views on whether the existing ROSH threshold is appropriate with regard to unaccompanied children and young people accessing SHS



Others reported that the ROSH threshold isn't itself the issue, pointing out that it "has a very clear definition which includes homelessness". They believed that the problems occurred after the ROSH report is referred to the local DCJ Community Services Centre (CSC) when it is usually "thrown in the bin" during the triage process because of competing priorities.

> "Children and young people presenting to SHS are homeless and should meet the ROSH threshold whether SHS are able to accommodate them for a period or not. It is only when they have no safe place to stay then and there that they meet ROSH."
>
> **SHS Manager**

> "Threshold is too high and does not consider other factors that may be present for children and young people. This can include risk taking behaviours of either parents or children and young people for example. Furthermore, the response time to obtain assistance is too long in some cases, and unfortunately, some young people are considered as being run aways when they leave the family home due to violence or other issues."
>
> **Frontline SHS Worker**

> "A significant amount of ROSH reports are to be made to receive any type of response from DCJ. Even if there is a response this is from a triage worker informing us that a young person will not be allocated as they do not reach the threshold. This has occurred numerous times when we have reported that young people between 12-15 years old are homeless with nowhere to reside. There is a significant need of support for these young people even if they are accommodated in a homeless youth program."
>
> **Frontline SHS Worker**

Recommendation: Revise the child protection assessment and triage process so that so a) children and young people being accommodated in youth homelessness services are still classified as 'homeless', and that all their presenting issues are taken in consideration and b) children and young people are assessed based on their vulnerability level – including risk to themselves – rather than age.

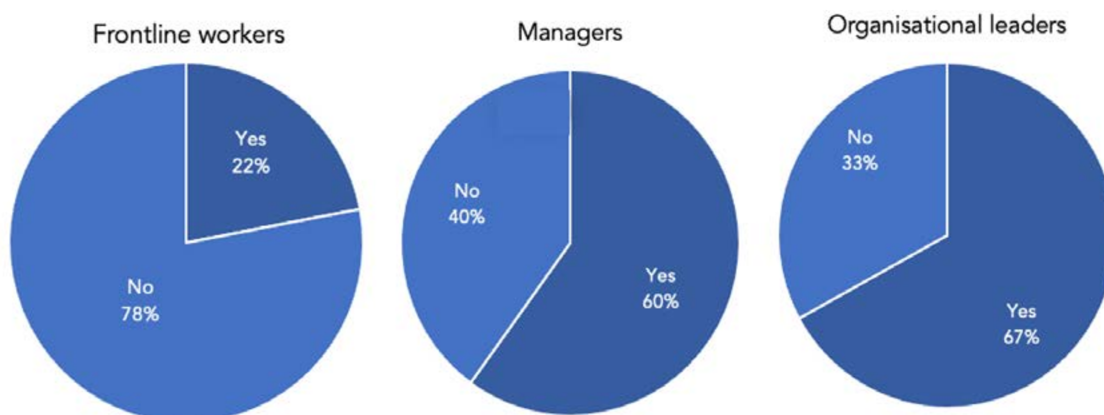
Cross-agency collaboration

In their 2018 More than shelter report, the NSW called on the DCJ to ensure that each CSC identifies a particular position responsible for acting as the contact point for SHS providers (NSW Ombudsman, 2018). DCJ addressed this recommendation, and district contacts were rolled out in mid-2019. A year later, the HYAP evaluation provided mixed reviews of the new system, noting:

> "Some providers stressed they had a strong and effective relationship with their district office through a dedicated contact which allowed them to engage DCJ services without going through the Helpline. Others were either unaware of a contact or thought that the contact did not materially change anything as "there's no change in resourcing so they can't really 'do anything'"
>
> **(Taylor et al., 2020)**

The findings of our sector survey were similarly mixed. As indicated in Chart 8, a substantial minority of organisational leaders and managers who responded to our survey were unaware of the nominated contact person in their local SHS.

Chart 8: SHS providers responses to the question, "Are you aware of the nominated contact person in your local CSC?"



Of those who were both aware of their nominated contact and had made contact with them, nine out of 19 provided positive reviews – noting that their contacts were "incredibly responsive and supportive", "great for pointing in the right directions", "useful and extremely child-focussed", "useful in enhancing sector collaboration" and "very efficient and knowledgeable". However, they also pointed out that the "many limitations" to what their contacts were able to do, and noted that their contacts "completely overworked and under resourced". Other suggested that the DCJ contact was not particularly useful, because they did not have enough influence, were slow to respond and repeatedly changed.

Recommendation: Ensure that a) DCJ have clear policy guidelines about the roles of the nominated SHS contact person b) every CSC has a nominated SHS contact person who at least the Manager Casework level of authority and c) that as part of their role, nominated contact people are required to reach out to all SHS providers – explaining who they are, and what the SHS provider can expect from them.

Performance targets

In addition to the caseworker overload, many of our informants felt that DCJ caseworkers unwillingness to assume responsibility for homeless adolescent reflected organisational performance targets – specifically the drive to reduce entries in OOHC.

DCJ's goal of reducing entries into OOHC is driven by good intentions. In the early 2000s, NSW had the highest and fastest growing rate of children in OOHC in Australia (AIHW 2002; AIHW 2004). Aboriginal children were vastly overrepresented in this system, being around ten times more likely to be in care (AIHW 2002). The rates of removal were condemned in widely publicised reviews in subsequent decades, as evidence that the child protection system was overwhelmed and 'crisis-driven' (Wood 2008; Tune 2016). At the same time, a growing body of child development research indicated that removals – while sometimes necessary to prevent serious harm – further exacerbated children's trauma and disrupted their attachments (Gauthier, Fortin and Jeliu, 2004).

This led to increased investments in prevention and early intervention services, as well as attempts to prevent unnecessary removals by promoting more collaborative practice among child protection workers. New models such as Group Supervision were introduced to increase shared decision-making among caseworkers, supporting them to 'sit with risk' rather than making 'reactive' removals (Wade et al. 2016). In recent years DCJ has celebrated the fact that the rates of children entering care in NSW have dropped to 1.2 per 1,000 - the lowest in the country for two consecutive years (DCJ., 2019).

Yfoundations welcomes this change in direction, which provides the opportunity for DCJ caseworkers to balance their "policing/investigative role" with a more "helping/supportive one" (Munro, 2013). However, following the advice of Professor Eileen Munro – a pioneer of the new "relational" approach – we would strongly advise against setting any targets on reducing the number of removals. As Munro points out: "Outcomes such as a reduction in removal rates may well be a consequence of good practice, but they can also be a consequence of reckless, poor quality decision making" (Munro, 2016).

This may be particularly true in circumstances when a young person is already separated from their parents, has no realistic prospect of returning home and would benefit from a child protection response.

Recommendation: Remove any formal or informal targets to reduce the entries into OOHC placements, since these decisions should always be made in the best interests of the child or young person and not influenced by organisational priorities.

Adolescent-specific caseworkers

Many SHS providers whom we spoke to stressed that they did not see individual child protection workers as being responsible for the lack of response to 12 to 17-year-olds. Instead, they felt that the system they worked in was overwhelmed. This means that DCJ caseworkers were forced to make tough choices – "I can help this teenager or that baby" – and more often than not that would prioritise the younger children.

Our interviewees suggested that this prioritisation reflects not only the risk assessment process process but also caseworker's skills and experience. Researchers from the Western Sydney University found that many caseworkers in the NSW child protection system "struggle with the complexity of working with adolescents in the context of limited casework time and the imperative to focus on the most immediate or presenting problem" (Schmied & Walsh, 2010). Caseworkers who did not have appropriate skills and knowledge often felt intimidated by their adolescent clients and would adopt strategies – such as not returning calls – to minimise their contact with them.

Given this, it is essential to have sufficient caseworkers within the NSW child protection system who specialise in working with adolescents: those who have the training to "remain calm and positive in the face of provocative trauma-driven 'pain-based behaviours'" (Ainsworth, 2017). Several interviewees mentioned that they previously had very productive relationships with adolescent caseworkers embedded withing local CSC or in units such as the previous Kings Cross Adolescent Unit. There was a perception that the number of adolescent caseworkers had declined in recent years; however, Yfoundations was unable to confirm this because the current DCJ Casework Dashboard does not distinguish between the types of caseworkers.

"It's getting tougher for us to get any sort of intervention from the Department…. They keep reforming things and not replacing what they're taking away…. In this area in particular, we actually had a couple of adolescent-specific workers, which were great. They're come in a spend a lot of time working jointly on case-management with young people. But they removed that from this area altogether. We did lose any resources, they just reshuffled them within the Department. But at the end of the day, we don't have those workers anymore. There are generalist workers who will help out in some ways. But we just can't get any sort of child protection intervention at all."

SHS Manager

Recommendation: Re-commit to rolling out Child Protection Adolescent Response Teams (CPART) across NSW, to provide child protection case management to 12 to 17-year-olds *and their families) who are not in OOHC care but have been reported to be at ROSH.

Recommendation: Provide more detailed information on the DCJ Caseworker Dashboard, showing the number of adolescent-specific caseworkers in each district.

Out-of-home care options

In addition to these 'demand' pressures facing DCJ caseworkers, our informants felt that there was also a 'supply' issue in the availability of appropriate placement options. It was widely perceived that the adolescents who needed Care and Protection Orders would not be appropriate for family foster care placements, and also "didn't want another family". Given the lack of alternative placements options, child protection workers saw "no point" in taking vulnerable young people into care, because they would not be able to provide them anything more suitable than an SHS placement. As noted in 2014 Child Death Annual Report, the lack of housing options also meant that, for DCJ caseworkers, "ensuring that a teenager has a bed for the night can be all-consuming and time-intensive"– leaving no time for them to address other presenting issues (NSW Government, 2014).

These supply issues highlight the desperate need for more supportive housing options for at-risk teens in NSW to meet the diverse needs of this cohort. One promising model is professional or 'Treatment Foster Care', whereby young people with high needs are placed with skilled, salaried and strongly supported foster carers, who provide one-on-one, around the clock supervision and mentoring. International evidence suggests well-designed Treatment Foster Care programs can reduce antisocial behaviour, absconding rates, criminal referrals and improve behaviour and school engagement (MacDonald & Turner, 2007) Yfoundations welcomes the current trial of the evidence-based Treatment Foster Care Oregon program, which is being offered to a small group of seven to 17-years-old in Campbelltown and Bankstown, however vastly more placements are needed across the state to meet the complex needs of adolescents who cannot live at home.

Another option is residential care. NSW has the lowest rates of residential care placements in Australia - only 3.4% of OOHC placement are residential care placements (Heyes, 2018) – and Australia has one of the lowest rates in the world (Ainsworth, 2017). This is generally seen as a positive thing, because of the historical failure of residential care – particularly for Aboriginal children (Australia., & Wilkie, M. 1997) – and research showing children in residential care generally have poorer outcomes than those in family placements (Li et al., 2019)

However, as researchers also highlight, these poor outcomes likely reflect the high needs of the service users rather than the service itself (Ainsworth & Hansen, 2005). Residential care is used as a 'last resort' placement for those who have severe behaviours challenges, most of whom have suffered the trauma of multiple family foster placement breakdowns (Ainsworth & Hansen, 2014). While evidence for outcomes in residential care is still emerging, meta-analyses suggest that well-developed models can improve psychosocial functioning (Knorth et al., 2008). New models of 'Therapeutic Residential Care', which provide "purposefully constructed, multi-dimensional living environments designed to enhance or provide treatment, education, socialisation, support and protection" (Whittaker, Del Valle & Holmes., 2015), are particularly promising.

'Secure care' models, in which therapeutic residential care is provided in a compulsory, restrictive setting, may also be necessary for those young people with the highest needs: namely, those who have a history running away from care, are likely to do so again, and to suffer significant harm in the process, as well as others who are at risk of causing harm to themselves or others (Thompson, 2018). NSW current has only one Secure Care facility, Sherwood House, which accommodates just six young people with extreme needs. If the state government was to expand these facilities, it essential that they are staffed by highly qualified, well-renumerated professionals who are capable of building "therapeutic alliances" with traumatised young people (Harder et al., 2012) and offering evidence based interventions (Brauers et al., 2016).

Recommendation: Expand evidence-based Treatment Foster Care programs across NSW, ensuring that professional carers are sufficiently skilled and supported to meet the high needs of traumatised children and young people.

Recommendation: Increase the number of residential placements in NSW, ensuring that these programs are sufficiently well-resourced to enhance or provide treatment, education, socialisation, support and protection.

Recommendation: Expanding the number of Secure Care placements for young people who present an extreme risk to themselves, and ensure these facilities are appropriately financed and staffed.

Case study
James* was 15 when he was referred to the regional youth refuge Trinton House* by a family friend who he was living with at the time. He had been reported to DCJ multiple times by his teachers, having disclosed that his mother's partner had physically and sexually abused him – including locking him in the boot of a car. This abuse continued when he moved to his aunt's house, before the family friend took him in temporarily.

Trinton House was provided little information about James when he entered the service, but it soon became apparent that he required intensive support. He had an intellectual disability and demonstrated problem sexual behaviours. This presented a risk to others in the refuge and prompted several young people to leave Trinton House. Staff were forced to supervise James 24 hours a day, including monitoring his bedroom door at night, which drained the refuges limited resources.

Trinton House managed to make contact with James' mother, but she flatly refused to have any contact with him. He did not know his father, and had no family and friends willing or able to care for him. The staff made daily reports to DCJ, imploring the local CSC to find a more suitable placement for him. DCJ reported the case to the police, with the aim of charging his mother with abandonment and neglect, but did not take James into care – implying that he was safe because he had accommodation.

After two months James left Trinton House and self-placed with a friend. When that placement promptly broke down, he had a period of couch surfing and street sleeping. James eventually returned to the refuge at 16, but had to be evicted after three weeks for taking drugs on site. Eventually, he was taken in by DCJ and put in a foster care placement, but this promptly broke down – and James continued couch surfing, street sleeping and intermittently staying at refuges until he aged out of the system.

The Trinton House managers think James would have benefited from a family-based response, such as a professional or 'treatment' foster care placement. This would have enabled him to receive the 24/7, therapeutic care he needed, while also learning what "it means to have a family".

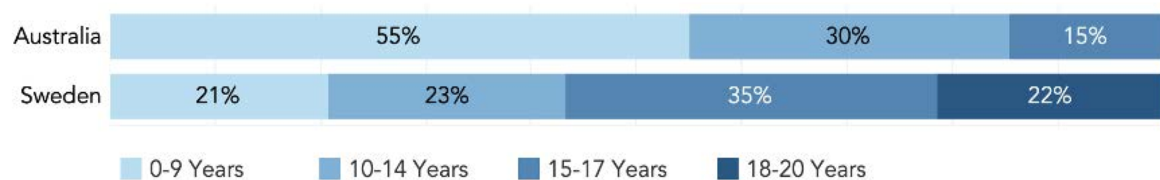
*Name changed for privacy

Voluntary out-of-home care

While many OOHC placements for high-needs adolescents are required by the state, our informants suggest that some parents – particularly those who are unable to handle their children's behaviours – would approve of therapeutic OOHC placements. Voluntary OOHC placements is a relatively novel concept in Australia, where states tend to take a 'child protection' approach to the issue of abuse and neglect – one which seeks to keep children safe by encouraging and investigating reports of maltreatment, and intervening when these reports are substantiated (Gilbert 2012). However, they are more common in European countries that take a 'family service' approach, which frames abuse and neglect more as a social problem addressed by supporting vulnerable families (Gilbert 2012).

For example, as of 2010, around 70% of OOHC placements in Sweden were voluntary (Healy et al., 2011). This means that either the parents had agreed to the placement or, if they are over 15, both the parent and young person had agreed. The voluntary approach means that there is a far greater number of adolescents in the Swedish OOHC than the Australian system – as this group are more likely to suffer from social and psychological problems which makes it difficult for them to live at home (see Chart 9) .

Chart 9: Children and Young People in Out-of-Home Care in Australia at June 2009 and Sweden at November 2009 by age category



Because of the widespread use of voluntary and involuntary OOHC, Sweden has historically had a very low rate of homelessness under 18 years olds – with national authorities reporting less 40 homeless under 18 year-olds in 2006 (Healy et al., 2011). These statistics suggest that there would be a benefit to promoting voluntary OOHC in NSW; however, such promotion would only be work if our state first addressed the shortage of supported housing options.

Recommendation: Promote voluntary OOHC as an option for young people with complex needs who can't live at home, but only after the issues with the supply of support housing options has been addressed.

Supporting appropriate young people in SHS

As many SHS providers noted, DCJ's unwillingness take adolescents into care prevents them from accessing the same funding that was available to other vulnerable young people who are unable to live at home. One of our informants described youth refuges are being the "poor cousin of OOHC", and others noted that young people in their refuges didn't receive nearly as much financial support – in terms of living allowances, brokerage, medical and psychological services and transitional support – as those under Care and Protection Orders.

Unit costs estimates support these statements. Estimates from the 2014-15 period suggested that the average cost of foster care placement in NSW was $45,507 per annum (Tune, 2016). Over the same time period, the average cost for providing a residential care placement in NSW was an estimated $189,532 per annum, and the average cost of therapeutic residential

placement was $310,144 per annum (Ainsworth, 2017). Yet in 2016 national report, the average cost of supporting and accommodating a young client in a Specialist Homeless Services program was estimated to be only $15,000 per annum (MacKenzie et al., 2016).

While SHS placements should never be considered an alternative to OOHC, there are many lower needs young people who are in secure and stable SHS medium-term placements. Medium term services provide 24/7 holistic wraparound support and trauma-informed care for two to three years, as young people complete their education or training, and develop critical living skills. Unfortunately, since the 2012 Going Home Staying Home, there has been a critical loss of medium-term youth homelessness services in NSW – leaving only three in metropolitan Sydney and one in the Illawarra. Young people must rely on short-term crisis accommodation instead, meaning they have to move every three months. The under-funding of the existing medium-term services also means they don't have enough staff to cover nights and weekends.

Policy changes have also reduced support to young people leaving these SHS. Prior to 2014, these young were eligible to receive the Transition to Independent Living Allowance (TILA) of $1500 to cover the basic costs of moving into independent living. Since then, however, this payment has been limited to only those leaving formal statutory OOHC. In addition to the TILA allowance, young people leaving OOHC are also eligible for Aftercare Support and the Premier's Youth Initiative (PYI). The PYI is a pilot program funded by DCJ across five sites, to provide services to young people leaving OOHC who are identified at risk of homelessness on exit from care. Young people are offered casework support, subsidised community housing support and education and employment mentoring, with the aim of building their skills and resilience to permanently divert them from the homelessness service system.

Like those in OOHC, young people are residing in SHS because they can't live at home. This means they have limited family support during the often difficult transition to adulthood. Yfoundations' believe these young people deserve the same funding and transition support as those in statutory placements.

"Decisions keep the young person in limbo until they attain a certain an age where they can enter into an SHS services, therefore they can be disadvantaged in the future due to not being eligible for after care services."

SHS Manager

Recommendation: Advocate to the Federal Government to broaden its eligibility criteria for Transition to Independent Living Allowance (TILA) to young people transitioning from SHS services.

Recommendation: Expand the Premier's Youth Initiative (PYI) to support young people to transition to independence from SHS across NSW.

Recommendation: Increase funding to allow SHS provers with the ability to provide Aftercare Support.

Prevention and early intervention

Reflecting the key experiences and concerns of our member organisations, this submission has focused on improving child protection responses to the 5,000 plus child and young people who present to SHS in NSW every year. While enhancing this crisis response is essential; however, a great deal more work also needs to be done to prevent the family breakdowns that are the driving force of youth homelessness in our state.

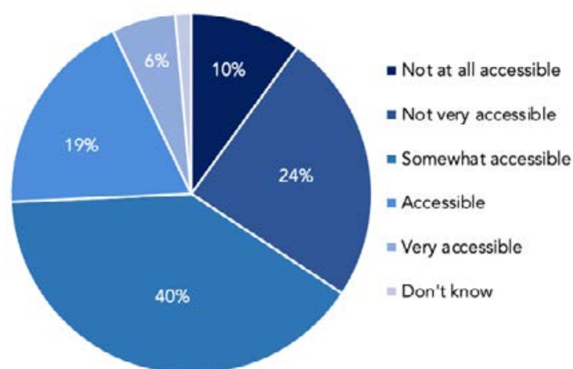
Over the last forty years, a body of evidence has developed demonstrating that interventions – particularly with infants and young children – can improve parenting skills and parent-child relationships to prevent entries into the child protection system. For example, randomised control trials have shown that:

- Positive parenting training based on social-learning theory can improve parent's mental health, relationships with partners and children, parenting skills and children's behaviour (Barlow & Coren, 2018; Rayce et al., 2017; Vlahovicova et al., 2017)
- Sustained home visiting by nurses, mental health professionals or para-professional to expecting families and families with young children improve child behaviour, health and reduce harsh parenting (Filene et al., 2013; Peacock et al., 2013; Sweet & Appelbaum, 2004)
- Attachment interventions that use psychotherapy to improve caregiver's reflection and sensitivity can increase attachment and improve caregiver-child interactions (Letourneau et al., 2015; Mountain et al., 2017)
- Supported playgroups facilitated by qualified childhood educators can lead to improvements in young children's behavioural skills & attachment (Schindler et al. 2015).

Numerous reviews of the child protection and OOHC system in the past 20 years have highlighted the NSW government's underfunding of early intervention services (NSW Standing Committee on Social Issues, 2002; Wood 2008; NSW Ombudsman 2011; Tune 2015). While financial commitments have increased over this time, the funds dedicated to early intervention still pale in comparison to those spent on child protection and OOHC. A recent submission to the Expenditure Review Committee shows that Target Early Intervention had a budget of just $159 million, while $643 million was spent on Child Protection budget and $1.3 billion on OOHC and Permanency Support.

The consequences of this underfunding were highlighted in the recent HYAP evaluation. While HYAP is branded as an 'early intervention strategy' to prevent homelessness and entry or escalation into the child protection system, most providers were contending with a "cycle of child protection involvement that is well under way" by the time a young person reached their services (Taylor et al., 2020). Many of the HYAP providers interviewed for the evaluation suggested that intervention and family support at a young age would have prevented issues escalating to this point. However, the report concluded that "few, if any" such services had been made available to this cohort (Taylor et al., 2020).

Chart 10: SHS survey respondent's assessment of the accessibility of services to prevent young people entering the child protection and homelessness system



These comments were reflected in Yfoundations consultation. As indicated in Chart 7, 34% of survey respondents reported that early intervention services were either "not at all accessible" or "not very accessible". Another 40% reported that services were "somewhat accessible".

Many of our interviewees also echoed these sentiments. While it has become the "new catchphrase" in child protection, they argued that DCJ don't "agree" or "know what they meant" by early intervention.

For example, 'early intervention' programs such as Brighter Future, Safe Care and Youth Hope only allow 10% of referrals to come from community organisations, regarding families who are at risk of escalation into the child protection system. Meanwhile, the vast majority of places within these programs are reserved for families who have met the ROSH threshold and been referred by a DCJ caseworker – those who are already well along the path to homelessness and OOHC.

Recommendation: Increase funding for evidence-based family support programs, and expand the eligibility criteria to ensure these programs genuinely offer 'early intervention'.

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